3) Provider Qualifications. (Continued)

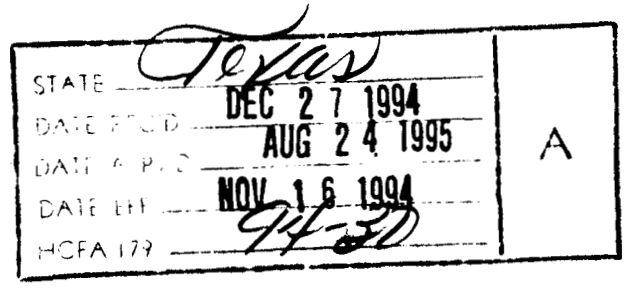
G. be serving a patient population in which more than 50 percent currently require institutionalization because of mental disease;

H. have a consistent historical pattern of accepting involuntary admissions;

I. assure, within a written provider agreement the capacity to: admit, readmit from alternative care, and treat both eligible persons voluntarily seeking services under the provision of the Health and Safety Code, Chapter 572 and persons lawfully compelled to accept inpatient mental health treatment under the provisions of the Health and Safety Code, Chapters 573 and 574;

J. ensure that inpatient hospital care will maintain the patient at, or restore the patient to, the greatest possible degree of health and independent functioning; and

K. allow access by the single state agency or its designee to the institution, the patient, and the patients records when necessary to carry out the agency's responsibilities and provide access to records in accordance with the provisions of Title 42 Code of Federal Regulations §431.107.



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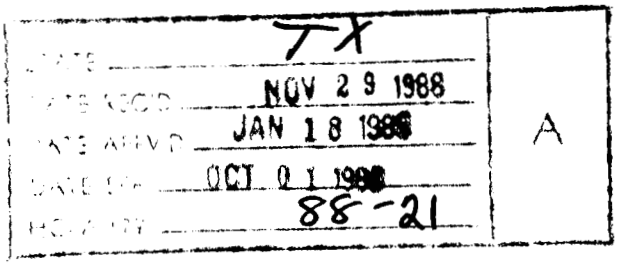
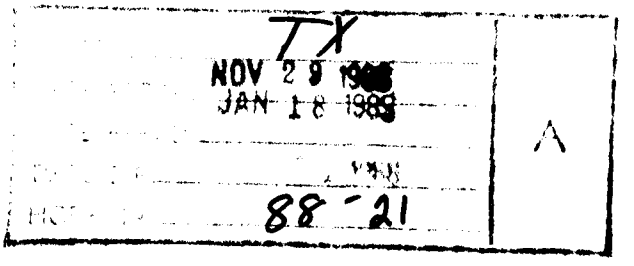
14.b. Services For Individuals Age 65 Or Older In Institutions For Mental Diseases - Skilled Nursing Facility Services.

Not provided.



14.c. Services For Individuals Age 65 Or Older In Institutions For Mental Diseases - Intermediate Care Facility Services.

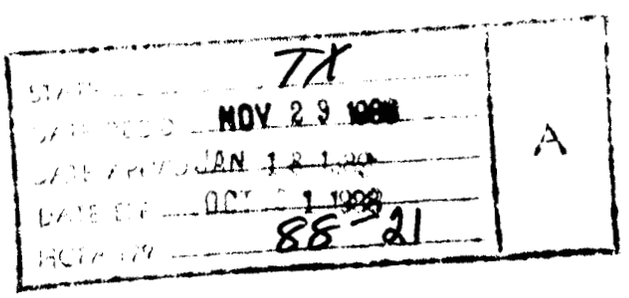
Not provided.



15.b. Intermediate Care Facility Services in a Public Institution (or Distinct Part Thereof) for the Mentally Retarded or Persons With Related Conditions.

Intermediate care facilities services (other than such services in an institution for mental diseases) are limited by:

The attending physician's prescription of a level of care setting and the single state agency's level of care determination for which vendor payments will be made.



15.b. Intermediate Care Facility Services in a Public Institution (or Distinct Part Thereof) for the Mentally Retarded or Persons With Related Conditions. (Continued)

Reimbursement methodology for ICF-MR dental services is described in 4.19-B, Item 24, page 17, and such dental services are limited to ICF-MR residents.

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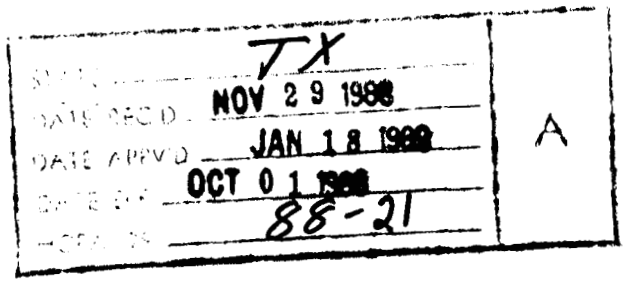
16. Inpatient Psychiatric Facility Services For Individuals Under 22 Years Of Age.

Not Provided.

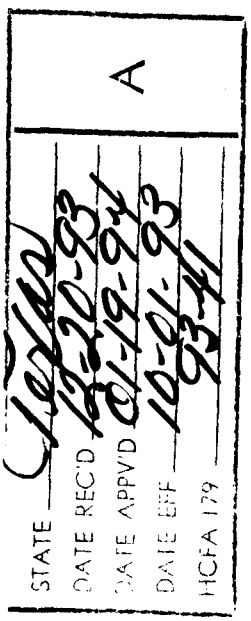


17. Nurse-Midwife Services.

In addition to the specifications, conditions, requirements and limitations established by the single state agency or its designee, which are applicable generally to all Medicaid providers in accordance with Federal law, rules and regulations, the following provisions are specifically applicable to Nurse-Midwife Services for purposes of the Texas Medical Assistance Program:

A. Nurse-Midwife services must be provided by a Certified Nurse-Midwife (CNM), enrolled and approved for participation in the Texas Medical Assistance Program. A Certified Nurse-Midwife is defined as a licensed registered nurse approved by the State Board of Nurse Examiners as an advanced nurse practitioner in midwifery, and who is also certified by the American College of Nurse-Midwives.

B. To the extent and under the circumstances authorized under State laws, rules and regulations, and in the case of services furnished in an institution, hospital or other facility to the extent permitted by the institution, hospital or facility, Nurse-Midwife Services are covered if the services:
   (1) are within the scope of practice for Certified Nurse Midwives, as defined by state law;
   (2) are consistent with rules and regulations promulgated by the Board of Nurse Examiners for the State of Texas or other appropriate state licensing authority; and
   (3) would be covered by the Texas Medical Assistance Program if provided by a licensed physician (M.D. or D.O.).



C. Home deliveries performed by a Certified Nurse-Midwife are covered when the single state agency or its designee has prior authorized the home delivery.

D. Certified Nurse-Midwives who manage the medical aspects of a case under the control and supervision of a physician in accordance with the rules of the State Board of Nurse Examiners and the Medical Practice Act will only be directly reimbursed by the Texas Medical Assistance Program for such services to the extent that they are performed under the written protocols required by the Board of Nurse Examiners and are not duplicative of other charges to the Medicaid program.

E. For services other than Nurse-Midwife Services, other applicable provisions of this Title XIX State Plan and the Texas Medical Assistance Program will apply.

F. Child birth education classes are not reimbursable.

17. Nurse-Midwife Services (Continued).

G. For purposes of coverage and reimbursement by the Texas Medical Assistance Program, deliveries by a Certified Nurse-Midwife, that are performed in a general or acute care hospital or special hospital or facility such as a birthing center, must be done in a hospital or facility licensed and approved by the appropriate state licensing authority for the operation of maternity and newborn services and approved by the single state agency for participation in the Texas Medical Assistance Program.

H. To participate in the Texas Medical Assistance Program, a Certified Nurse-Midwife must identify the licensed physician or group of physicians with whom an arrangement has been made for referral and consultation in the event of medical complications. If the collaborating physician or group is not a participating provider in the Texas Medical Assistance Program, the Nurse-Midwife must inform recipients of their potential financial responsibility in accordance with requirements of the Texas Medical Assistance Program applicable to all Medicaid providers. If and when the physician or group with whom an arrangement has been made for referral and consultation in the event of medical complications is changed or cancelled, the CNM must notify the single state agency or its designee in writing of the identity of the new physician or group within two weeks after the cancellation or change.

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TN No. 88-21
Supersedes TN No. See HCFA-179

Approval Date JAN 18 1989

Effective Date OCT 1 1988

18. Hospice Care.

The Texas Department of Human Services (TDHS) administers the Texas Medicaid Hospice Program through provider enrollment contracts with hospice agencies. These agencies must be licensed by the Texas Department of Health (TDH) as Class A hospice agencies and Medicare certified as hospice agencies by the Health Care Financing Administration (HCFA), Department of Health and Human Services. Coverage of services in the Texas Medicaid Hospice Program follows the amount, duration, and scope of services specified in the Medicare Hospice Program, with the following three exceptions.

1. The Texas Medicaid Hospice Program has unlimited benefit periods of unlimited duration.
2. The Texas Medicaid Hospice Program does not have a maximum number of days for which a recipient can receive hospice services under Medicaid.
3. The Texas Medicaid Hospice Program does not allow cost sharing to be imposed on Medicaid recipients for hospice services rendered to Medicaid recipients.

The recipient must file a Medicaid election statement with a particular Medicaid hospice provider. In doing so, the recipient waives rights to other [TDHS] Medicaid services that are related to the treatment of his terminal illness(es), and that are also provided by Medicare. The recipient has the right to cancel the election at any time without forfeiting additional Medicaid hospice coverage at a later time. The recipient does <u>not</u> waive rights to TDHS services for conditions not related to the terminal condition. Dually eligible (Medicare and Medicaid) recipients must participate in the Medicare and Medicaid hospice programs simultaneously in order to receive Medicaid hospice services.

STATE Texas
DATE RECD 9-16-92
DATE APPVD 9-22-92
DATE EFF 8-1-92
HCFA ID 92-34
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19. Case Management Services - Chronically Mentally Ill

See Supplement 1 to Attachment 3.1-A, page 1A